# Massachusetts Department of Public Health
# Office of Emergency Medical Services
# **Part B-1:** Service Area

1) Service Number

2) Ambulance Service Name

**In Column #3** list the communities in which you regularly respond to emergency calls. Circle "full" if you are the primary emergency provider for the entire community (attach written explanation). Indicate whether or not your service is the municipality designated emergency service. Indicate whether or not you respond only to a unique population (state institution, industrial plant, university, etc.)
**In Column #4** list those ambulance services to which your service provides back up.

**Please list those communities or portions of communities in which you routinely respond to emergencies.**

| OEMS use only | 3) Primary Emergency Coverage City / Town Name | Cover Full/Part Town | Municipal Designate | Unique Pop. |
|---|---|---|---|---|
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |
| | | FULL<br>PART | YES<br>NO | YES<br>NO |

**Please list those Ambulance Services your service backs up**

| OEMS use only | 4) Back-up Ambulance Services Service Name |
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**Massachusetts Department of Public Health**
Office of Emergency Medical Services
# Part B-2: Back-up Ambulance Services

1) Service Number

2) Ambulance Service Name

| | **3) List all the services that provide back-up to your service.** | **4) Identify which part(s) of your service are covered by each service.** |
|---|---|---|
| OEMS use only | Service Name | City / Town / State |
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